TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS BONE & JOINT CENTER

Respondent Name
AMERISURE MUTUAL INSURANCE CO

MFDR Tracking Number
M4-15-3182-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are claims/claim that were submitted to you, but have not been paid as of this date. Amerisure has denied payment on these charges because of a failure to meet the applicable timely claim filing requirement.

We must follow the requirements of our Contract with Amerisure and In this case, we did submit our charges to you within the time frame allowed. We have enclosed a Mail Log of the billing record which is proof that the charges were billed on time. This is a permanent record in our billing system and cannot be modified. This log follows §21.816 Date Of Receipt of the Texas Department of Insurance. As per part C of this section, "If a communication is submitted by United States mail, first class, the communication is presumed to have been on the fifth day after the date the communication is submitted." Therefore, we can only presume the claim has been received by your company five days after we mailed claim."

Amount in Dispute: $2,500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have reviewed this request and find there is no additional fee due to the provider. The provider has failed to provide evidence supporting that the exception to the timely filing rule is applicable.

Of note, the 10/29/2013 date of service in question was originally submitted by the provider to Amerisure Mutual as a claim for date of service 10/30/2013. The report attached to the CMS 1500 was for the date of service performed on 10/29/15. This 10/30/13 date of service was received by Amerisure Mutual on 3/11/2014, a total of 133 days from the date of service of 10/29/2013. The bill was processed and denied per Rule 133.20 as the time limit for filing had expired."

Response Submitted by: Amerisure Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 29, 2013	CPT Code 73221	$2,500.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

> Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
>
> (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The date of the services in dispute is October 29, 2013. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on May 28, 2015. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		6/19/15
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.